STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155176	A. BUILDING 00 B. WING	12/02/2011

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GLENBROOK REHABILITATION & SKILLED NURSING CENTER	3811 PARNELL AVE FORT WAYNE, IN46805

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F0000	This visit was for a Recertification and State Licensure Survey. Survey dates: November 28, 29 & 30, December 1 & 2, 2011 Facility number: 000092 Provider number: 155176 AIM number: 100266090 Survey team: Angela Strass RN TC Sue Brooker RD Rick Blain RN Sheryl Roth RN Census bed type: SNF/NF: 67 Total: 67 Census payor type: Medicare: 4 Medicaid: 53 Other: 10 Total: 67 Stage 2 sample: 35 These state findings are cited in accordance with 410 IAC 16.2. Quality review completed 12/8/11	F0000	The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or any violation of regulation. This provider respectfully requests that the 2567 plan of correction be considered the letter of credible allegation and request a desk review in lieu of a post survey review on or after December 29, 2011.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Cathy Emswiller RN			
F0241 SS=D	The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Based on observation, interview and record review the facility failed to respect the dignity of 1 resident (Resident #53) in the stage 2 sample of 35 residents. Finding include: Review of the clinical record for Resident #53 on 11/30/11 at 2:36 p.m., indicated the following: diagnoses included, but were not limited to, epilepsy, depression, congestive heart failure, and anemia. A Minimum Data Set (MDS) assessment for Resident #53, dated 6/10/11, indicated a BIMS (Brief Interview of Mental Status) indicated a score of 11 out of 15, which indicated moderate mental impairment. During an observation of the lunch meal on 10/28/11 at 11:55 a.m., Resident #53 was seated at her dining table in the dining room. The	F0241	F 241: Dignity and Respect of Individuality:It is the practice of this provider to promote care for all residents in a manner and in an environment that maintains or enhances each resident's dignity and respect. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Social Service Director interviewed Resident #53 in regards to events. Resident #53 was offered to change tables in dining room and refused. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents have the potential to be affected by alleged deficient practice. Residents sitting at same table as Resident #53 were interviewed and were not agitated by visitors going by the table during meal times. All staff in-serviced on 12/02/11 and again on 12/13/11 by Social Services Director on following main pathway in the dining room and to not take shortcuts by resident's table during meal times. Tables were re-arranged	12/29/2011

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	dining room in the facility was observed to be divided into two sections, with each section defined by three floor to ceiling columns in the middle of the dining room defining a walkway from the front hall of the facility through the dining room. The walkway then designated a turn to the right toward the 100 Hall which staff and visitors were to use when moving from the front hall of the facility through the dining room into the 100 Hall. Resident #53's dining table was located on the right side of the dining room at the front left corner immediately next to the walkway where it turned from the dining room toward the 100 Hall. The tables in the dining room were placed at an angle that allowed a visual and physical shortcut from the dining room into the 100 Hall and back right next to the dining table of Resident #53. During the observation on 11/28/11 at 12:08 p.m., a male teenage visitor was observed to make the shortcut through the dining room from the 100 Hall immediately next to Resident #53's table. Resident #53 became angry and was heard to inform the male teenage visitor he needed to go around her table on the walkway. She also informed him going next to her table was not a cut-through. At		on 12/06/11 in the dining room to eliminate the short cut path. What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur? All staff in-serviced on 12/02/11 and again on 12/13/11 by Social services Director on following main pathway in the dining room and to not take shortcuts by resident's table during meal times. Tables were re-arranged on 12/06/11 in the dining room to eliminate the short cut path. Department Managers and/or Unit Manager is assigned to all meals daily to monitor and document that dining room is not being used as a pathway. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? Dining room manager and/or nursing supervisor will monitor, using the Meal Service/Dignity CQI form for compliance for daily for 2 weeks, then weekly for 2 months, then quarterly for 6 months and forward results to monthly CQI committee for review. If any findings are out of compliance, then monitoring and an additional action plan will continue as determined by the committee. Compliance threshold is 90%. Non-compliance may result in disciplinary action up to and including termination.	

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	12:13 p.m., a female visitor and a female child were observed to also cut-through the dining room from the 100 Hall next to her dining table. Resident #53 was observed to become upset with them as well. At 12:20 p.m., an outside vendor to the facility was observed to pull a flat bed cart loaded with green duffel bags through the same area next to her table. Resident #53 was observed to become upset and shake her head. At 12:22 p.m., two un-identified staff were observed to do the same thing. Resident #53 was eating her lunch meal during the observation. Resident #53 was interviewed on 11/29/11 at 1:24 p.m. During the interview she indicated people were not to cut through the dining room next to her table. She also indicated she was bothered by people walking by her table so closely while she was eating. She further indicated she had talked to the facility about this and they informed her people were not to do this, but they kept doing it anyway. During an observation of the lunch meal on 11/30/11 at 11:32 a.m., Resident #53 was seated at the same spot at the same dining table. At 11:38 a.m., LPN #2 was observed to make the shortcut through the dining			

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	room next to Resident #53's table into the 100 Hall, followed by the Director of Nursing at 11:39 a.m. At 11:46 a.m., a visitor to the facility was observed coming from the outside into the dining room and made the shortcut through the dining room next to Resident #53's table into the 100 Hall. At 12:02 p.m., Physical Therapy #3 was observed to make the shortcut through the dining room next to Resident #53's table into the 100 Hall and at the same time an un-identified staff member walked from the 100 Hall through the dining room next to Resident #53's table to the front hall of the facility. At 12:08 p.m., an outside Hospice nurse to the facility was observed coming from the outside into the dining room and wander through the dining room among many dining tables ending up walking next to Resident #53's table on her way to the 100 Hall. She was not observed to use the designated walkway at all. At 12:10 p.m., an un-identified housekeeping aide was observed to make the shortcut from the 100 Hall through the dining room next to Resident #53's table to the front hall of the facility. At 12:15 p.m., the same un-identified housekeeping aide was observed coming from the outside into the dining room and made the shortcut through the dining			

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	room next to Resident #53's table into the 100 Hall. Resident #53 was observed eating her lunch meal during the observation. A current facility policy "Resident Handbook, Residents' Rights & Advanced Directives", with a revision date of January, 2011, indicated "...The resident has a right to a dignified existence...A facility must care for its residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality...." 3.1-3(t)			

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F0272 SS=D	The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and Documentation of participation in assessment. Based on record review and interview, the facility failed to ensure the accurate documentation for incontinence status on the Minimum Data Set (MDS) Assessment for 1 of 1 resident Resident #90) who met the criteria for urinary incontinence, and failed to accurately assess the dental status of 1 of 3 residents (resident #55) who met the criteria for dental	F0272	F 272: Comprehensive Assessments:It is the practice of this facility to conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident #90's assessment was modified	12/29/2011

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	status and services in a Stage 2 sample of 35. Findings include: The record for Resident #90 was reviewed on 11/30/11 at 9:30 a.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease, anxiety, depression, high blood pressure and coronary artery disease. An External Transfer Report, dated 8/11/11, indicated Resident #90 was incontinent of urine at times. The Activities of Daily Living (ADL) record, dated 09/06/11, indicated Resident #90 was incontinent of urine three (3) times during the seven day assessment period. The MDS, dated 09/06/11, indicated the resident was always continent of urine. The Activities of Daily Living (ADL) record, dated 10/8/11, indicated Resident #90 was incontinent of urine eighteen (18) times during the seven day assessment period. The MDS, dated 10/8/11, indicated the resident was always continent of urine. The Observation Report, dated 11/19/11, indicated Resident #90 was		to accurately reflect the urinary incontinence on 12/14/11. Resident #55 was assessed for any pain with gums and/or mouth and no pain was noted. Resident #55 does not want a dental appointment immediately, at resident's request of wanting to wait 3 to 4 months, so an appointment was made for March 5, 2012. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents have the potential to be affected by alleged deficient practice. MDS Coordinator and/or designee will review resident's recent assessments for urinary incontinent accuracy. Social Service Dire tor and/or designee will review all residents' most current dental assessment for any dental needs and follow up accordingly. What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur? MDS Coordinator and/or designee will review all resident's recent assessments for urinary incontinent accuracy. Resident Assessment Specialist will review all residents' incontinent assessments for accuracy. MDS Coordinator has been educated on the importance of accurate assessments by Resident Assessment Specialist on 12/13/11. Social Service Director	

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	incontinent of both bowel and bladder. The Activities of Daily Living (ADL) record, dated 11/5/11, indicated Resident #90 was incontinent of urine three (3) times during the seven day assessment period. The MDS, dated 11/5/11, indicated the resident was always continent of urine. The Activities of Daily Living (ADL) record, dated 11/9/11, indicated Resident #90 was incontinent of urine two (2) times during the seven day assessment period. The MDS, dated 11/9/11, indicated the resident was frequently incontinent of urine. The Urinary Continence coding sheet for the MDS, dated May 2010, was provided by the MDS nurse on 11/30/11 at 11:11 a.m. The coding instructions, included, but were not limited to the following: - Always continent: if throughout the 7-day look-back period the resident has been continent of urine, without any episodes of incontinence. - Occasionally incontinent: if during the 7-day look-back period the resident was incontinent less than 7 episodes. This includes incontinence of any amount of urine sufficient to dampen undergarments, briefs, or pads during daytime or nighttime.		and/or designee will review all residents' most current dental assessment for any dental needs and follow up accordingly. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? Interdisciplinary Team will review all assessments and compare to ADL sheets, during care plan review for accuracy with the continence on weekly basis during care plan review. MDS Coordinator and/or designee to perform Bladder Program CQI form to monitor for continent accuracy weekly for 4 weeks, monthly for 3 months, and then quarterly for 6 months and forward findings to monthly CQI committee for review. Threshold of CQI is 90% and an additional action plan will be created by CQI committee for any findings out of compliance. Social Service Director and/or designee to perform the Dental Service CQI for dental services weekly for 4 weeks, monthly for 3 months, and then quarterly for 6 months and forward findings to CQI committee monthly for review. An additional action plan will be developed by the CQI committee for any findings below threshold of 90%. Resident Assessment Specialist will review a random sample of incontinent assessments every 2 weeks for 4 weeks and then quarterly thereafter with findings forwarded	

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	- Frequently incontinent: if during the 7-day look-back period, the resident was incontinent of urine during seven or more episodes but had at least one continent void. This includes incontinence of any amount of urine, daytime and nighttime. During the record review on 11/30/11 at 10:15 a.m., there was no care for urinary incontinence only one that stated to assist with toileting as needed. An interview was conducted with the MDS nurse on 11/30/11 AT 10:10 A.M. During the interview, the MDS nurse indicated she doesn't always trust the coding on the ADL records. She indicated she talks with staff as well as using the ADL sheets but that Resident #90's abilities fluctuated. An interview was conducted with CNA #1 on 11/30/11 AT 10:17 a.m. During the interview, CNA #1 indicated Resident #90 was occasionally incontinent of urine. Surveyor: Strass, Angela M.		to the monthly CQI committee for review. Resident Assessment Specialist will review all residents' incontinent assessments for accuracy. Interdisciplinary Team will review oral assessments during residents' care plan review.	

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	Observation of resident #55 on 11/28/11 at 2:00 p.m. indicated the resident had broken and decayed teeth on the upper and lower portion of her mouth. On 11/30/11 at 10:15 a.m. review of the resident's admission nursing assessment dated 4/5/10 indicated the resident had reddened gums. Review of the quarterly MDS (minimum data set) dated 9/22/11 there was no assessment marked in the dental section. On 12/2/11 at 10:30 a.m. Interview with the Director of Nursing indicated she did not have any information regarding resident #55 being seen by a dentist. The only information was the initial assessment of the resident's teeth which indicated reddened gums. On 12/2/11 at 10:33 a.m. interview with the Social Service Director indicated the resident had not been seen by a dentist and she does not have any documentation of the resident being asked on admission if she needed/wanted to be seen by the dentist. 3.1-31(d) .			

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F0279 SS=D	A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). Based on observation, interview and record review, the facility failed to initiate a care plan for behaviors for 1 resident (#75) and also failed to develop a care plan for a wheelchair cushion for 1 resident (#69) of 35 residents reviewed for care plans in the stage 2 sample of 35. Findings Include: 1. Review of the clinical record for Resident #75 on 11/30/11 at 10:24 a.m., indicated the following: diagnoses included, but were not limited to, acute cerebrovascular disease, hypertension, atrial	F0279	F279: Develop Comprehensive Care Plans:It is the practice of this facility to use the results of the assessment to develop, review, and revise the resident's comprehensive plan of care. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Nursing staff was educated on 11/25/11 by Social Service Director and Assistant Director of Nursing verbally about interventions in place regarding Resident #75's behavior. Resident #75 care plan and C.N.A. assignment sheet was updated on 11/30/11. Cushion put on resident #69's chair on 12/01/11 and care plan and C.N.A. assignment sheet was	12/29/2011

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	fibrillation, osteoarthritis, dysphagia, diabetes mellitus, and hemiplegia. A current physician's order for Resident #75, dated for the month of December, indicated Lexapro 10 mg daily for depression. A Behavioral Medicine Evaluation & Management Note for Resident #75, dated 11/17/11, indicated his insight and judgement were fair from a scale of poor, fair, good, or excellent. A Nursing Progress Note for Resident #75, dated 11/25/11 at 9:48 p.m., indicated "...Writer alerted to res (resident) in hallway touching other res inappropriately, res educated on 0 (zero) touching other res, states that staff reporting the issue is a trouble maker, writer notified social services, ADON notified, notified res wife...." A Social Service Progress Note for Resident #75, dated 11/25/11 at 4:25 p.m. and recorded as a late entry on 11/30/11 at 9:28 p.m., indicated "...Writer spoke with resident regarding nursing report related to him touching female resident on breast. Resident voiced that aid (sic) who reported it was trying to make trouble for him. He stated he was trying to give resident a hug. He		updated. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents have the potential to be affected by the alleged deficient practice. All residents place on Behavior Management care plan will be reviewed by comparing the C.N.A. assignment sheet to care plans for accuracy by Social Services Director. Director of Nursing will review all residents with potential for skin breakdown and place cushions on wheelchair if needed and update care plans and C.N.A. assignment sheets to reflect change. What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur? Nursing staff to be in-serviced on Behavior Management policy by DNS and/or designee by 12/29/11. New interventions, which may include 15-minute check, will be initiated by charge nurse immediately with any new or worsening behavior that occurs on off hours. Charge nurse will inform/in-service all applicable nursing staff on all interventions to reduce or eliminate any new or worsening behaviors. Resident will be placed on hot charting for new or worsening behavior. Nursing staff to be in-serviced on Behavior Management policy by DNS and/or designee by 12/29/11. Resident skin	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	voiced he did nothing wrong or that he was ashamed of. Writer reminded him that he is married and that if female resident voiced she did not want to be touched or that he hurt her, he could be charged with assault. He voiced understanding. Writer reminded him that he can shake hands with other peers but he is not to hug, rub arm or kiss them. He stated he knew writer was doing her job and looking out for him and that he would remember what was asked but that he still felt he did not do anything wrong...." An IDT (Interdisciplinary Team) Progress Note for Resident #75, dated 11/25/11 at 4:30 p.m. and recorded as a late entry on 11/30/11 at 9:32 p.m., indicated the ADON and Social Service Director were present. The progress note also indicated "...Upon hearing incident where it was reported that resident had touched a female resident's breast outside of clothes, team determine that resident would be placed on a behavior plan. During incident, removing resident from situation and speaking with him were effective strategies. This is new behavior for resident and reportable. Female peer was not affected by interaction at this time...."		assessments are performed weekly and residents identified with potential for skin breakdown will have a cushion placed on wheelchair and c are plan and C.N.A. assignment sheets will be updated. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? Social Services Director and/or designee will utilize the Behavior Management CQI form weekly for 4 weeks, monthly for 3 months, then quarterly for 6 months thereafter. Results will be forwarded to the CQI committee monthly for review. An additional action plan will be developed by the CQI committee for any findings below threshold of 90%. DNS and/or designee will use the Care Plan Updating CQI form weekly for 4 weeks, then monthly for 3 months, then quarterly for 6 months to monitor for compliance. Results will be forwarded to the CQI committee monthly for review. An additional action plan will be developed by the CQI committee for any findings below threshold of 90%. Non-compliance may result in disciplinary action up to and including termination.	

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	155176	A. BUILDING 00 B. WING	12/02/2011

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	An All Staff Behavior Tracking Record for Resident #75, dated 11/26/11 at 3:15 p.m., indicated "...Resident in middle of hall rubbing on [female] resident's breast. Approached resident, removed his hand off of female resident's breast. Resident became agitated saying it's not what you think. Writer removed [female] resident. Resident following writter (sic) down hall saying trouble maker...." A Nursing Progress Note for Resident #75, dated 11/27/11 at 9:46 a.m., indicated "...Resident has had no behavioral issues seen by this writer, however female resident reported inappropriate conversation was made to her...." AN All Staff Behavior Tracking Record for Resident #75, dated 11/27/11, indicated "...Resident [female] stated 'Resident #75 came in to my room and asked me if I knew what a [documented sex act] was', and it made me uncomfortable...." A written investigation by the Social Service Director, dated 11/28/11, indicated "...Writer spoke with [female resident] on November 28, 2011 at approx. (approximately) 2:55 pm to discuss an interaction that occurred			

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	on 11/27/11 with resident [Resident #75]...[Female resident] voiced that [Resident #75] entered her room, which he has done before and grumbled something that she did not understand, but [Resident #75] went on to ask if she knew what was going on around the building. She stated no and then he voiced that people were trying to get him into trouble and then asked if she knew what a [documented sex act] was which she said shocked her. She said she was not scared just surprised and felt like [Resident #75] was trying to get her on his side...." Review of the current care plans, with the initiation dates of 3/4/11, 3/8/11, 3/14/11, 4/6/11, 4/26/11, 5/19/11, 8/5/11, and 8/7/11, in the clinical record for Resident #75 did not include any care plan addressing behaviors. LPN #11 was interviewed on 11/30/11 at 3:20 p.m. During the interview he indicated nursing staff were notified when to do behavior charting on residents. He also indicated behavior charting had been initiated on Resident #75 on 11/25/11 and was closed on 11/29/11 due to behavior being resolved. He further indicated charting was to be done on each shift.			

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The Director of Nursing was interviewed on 12/1/11 at 3:15 p.m. During the interview she indicated a behavior care plan was the same thing as a behavior plan.

The Assistant Director of Nursing was interviewed on 12/1/11 at 4:04 p.m. During the interview she indicated Resident #75 was placed on the facility's "hot charting" on 11/25/11 due to the incident with another female resident. She also indicated "hot charting" meant nursing staff were to chart on Resident #75 each shift. The Assistant Director of Nursing further indicated the facility had behavior books containing behavior plans which described each resident's behaviors and interventions staff were to use if the behavior occurred. She also indicated Resident #75 did not have a behavior plan developed on 11/25/11, but only had "hot charting" done.

A current undated facility "ASC Behavior Management Policy & Procedure", provided by the Administrator on 12/2/11 at 10:15 a.m., indicated "...Care plan should be initiated for any behavioral issue that affects, or has the potential to affect, the resident or other

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	residents...The behaviors that have been identified as requiring monitoring and associated interventions identified on the care plan should then be transferred to the monitoring form...The behaviors and interventions identified on the Behavior Monitoring are also listed on the CNA (Certified Nursing Assistant) assignment sheet to assist in communication of individualized interventions...New or worsening behaviors are reviewed by the IDT...The IDT review should be a discussion with the team as to the behavior event, and evaluation of interventions, presentation of new interventions if applicable and an assessment of any underlying causes of the distressed behavior...." A current facility Resident Care/Need Sheet for Resident #75, provided by the Director of Nursing on 12/1/11 at 4:15 p.m., did not indicate Resident #75 had any behaviors which were to be monitored or any interventions which were to be followed if a behavior occurred.			

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	2. On 11/30/11 at 12:00 p.m. observation of resident # 69 indicated he was seated in his wheelchair at the dining room table. The resident was not observed to have a pressure reduction cushion. On 11/30/11 at 2:00 p.m. Resident #69 was observed seated in the activity room in his wheelchair. The resident was not observed to have a pressure reduction cushion. On 12/1/11 at 8:15 a.m. Resident #69 was seated in his wheelchair in the dining room. The resident was not observed to have a pressure reduction cushion. **On 12/1/11 at 9:00 a.m. Interview with the DON indicated she thought the resident had a pressure reduction cushion for his wheelchair.** **On 12/1/11 at 10:30 a.m. review of the Annual MDS (minimum data set assessment) dated 10/5/11 indicated resident #69 was totally dependent on staff for all of his activities of daily living. Review of the Care plans on 12/1/11 at 10:35**			

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	a.m. for resident #69 indicated he was at risk for skin breakdown. Review of the care plan did not indicate the resident was to have a pressure reduction cushion. **On 12/1/11 at 10:45 a.m. review of the facility policy "Care Plan Review and Maintenance" dated 1/2010 and revised on 8/2011, indicated the following:** **Policy: It is the policy of this facility that each resident will have a comprehensive care plan developed and based on comprehensive assessment. The care plan will include measurable goals and resident specific interventions based on resident needs and preferences to promote the residents highest level of functioning including medical, nursing, mental and psychosocial needs.** **Procedure: Care plan problems, goals and interventions will be updated based on changes in resident assessment/condition, resident preferences or family input.** **3.1-35(a)**			

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F0280 SS=D	The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. Based on record review and interview, the facility failed to revise the dietary care plan for 1 resident with a low albumin (measure of nutritional status) (Resident #40) and failed to ensure a responsible party was invited to care plan meetings for 1 resident (#69) of 1 who met the criteria for care planning in the stage 2 sample of 35. Findings include: 1. The record for Resident #40 was reviewed on 11/30/11 at 10:30 a.m.	F0280	F 280: Right To Participate Planning Care:It is the practice of this facility to recognize that residents have the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes made in the care or treatment. It is also the practice of this facility to update and or develop a care plan within 7 days after the completion of a comprehensive assessment. What corrective action(s) will be accomplished for those residents found to have been affected by	12/29/2011

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	Diagnoses included, but were not limited to, end stage congestive heart failure, end stage renal disease, dementia, chronic obstructive pulmonary disease, and diabetes mellitus. The "Resident will be served prescribed diet," care plan, dated 9/22/11, indicated to serve a regular diet, monitor food consumption's, monitor labs, monitor weights, and that Resident #40 preferred to eat her meals in her room. There were no references to the residents low albumin levels nor to the interventions in place for them. The following laboratory reports were noted in the clinical record: 09/23/10 pre albumin level 13.2 (18.0-35.7). albumin level 2.3 (3.4-5.0) 02/10/11 pre albumin level 13.3 (18.0-35.7) 06/16/11 pre albumin level 3.8 (18.0-35.7), albumin 2.0 (3.4-5.0) The "Resident Progress Notes, "dated 8/24/11 by the Dietary Manager, indicated "...Resident remains on a regular diet...resident receives high potency vits (vitamins) and minerals...and beneprotein one scoop once a day...."		the deficient practice? Resident #40 care plan updated on 12/15/11. Resident #69's responsible party was notified of the right to attend care conferences quarterly on 12/16/11. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents have the potential to be affected by the alleged deficient practice. All residents and/or responsible parties will be invited to quarterly care meetings. Dietary Manager and/or Registered Dietitian will audit all dietary care plans for any updates needed. What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur? Registered Dietitian educated the Dietary Manager on policy regarding revising care plans on 12/15/11. Dietary Manager will review all care plans and update nutritional care plans when completing the MDS assessment. DNS and/or designee will update Registered Dietitian alert sheets for residents of nutritional concern, wounds, weight changes, and abnormal labs relating to nutritional status on a weekly basis. All residents and/or responsible parties are invited quarterly (or more often as needed) to participate in care plans. Invite will be documented in clinical record. Social Services	

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	The current meal tray card for Resident #40, was provided by the Dietary Manager on 12/01/11 at 11:06 a.m. The tray card listed Resident #40 as being on a regular diet with no special dietary supplemental interventions. The most recent "Routine Medications" list, dated 12/1/11, indicated Resident #40 was receiving beneprotein powder (protein supplement) once daily effective 4/5/11. A telephone interview was conducted with the Registered Dietitian (RD) on 12/2/11 at 1:47 p.m. During the interview, the RD indicated she had not been notified of the low albumin levels. She indicated she is in the facility once a week or every other week and sees the residents on the alert sheet. Those residents with weight loss, wounds, etc. She further indicated she had not seen Resident #40 since she started her RD position back in July. The Certified Dietary Manager (CDM) was interviewed on 12/2/11 at 1:47 p.m., along with the RD. During the interview, the CDM indicated Resident #40 had refused supplements in the		Director educated by Executive Director on the policy of inviting resident and/or responsible party to all care conferences on 12/21/11. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? Social Services Director and/or designee will use the Care Plan Review CQI audit form weekly for 4 weeks, monthly for 3 months, then quarterly for 6 months thereafter. Results will be forwarded to CQI committee monthly for review. An additional action plan will be developed by the CQI committee for any findings below threshold of 90%. Registered Dietitian to review a random sample of dietary care plans monthly and forward findings to the CQI committee monthly for review.	

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	past and that she had tried other interventions such as peanut butter and toast 2. On 11/29/11 at 2:15 p.m. Interview with resident #69's responsible party indicated she had only been to one care plan meeting in the last year. When queried she indicated she thought they only had meetings on a yearly basis. On 12/1/11 at 2:30 p.m. interview with the Social Service Director indicated the residents family/responsible party is notified by mail and a copy of the notification is kept in the clinical record. On 12/1/11 at 2:45 p.m. the Social Service Director presented copies of the care plan notification for resident #69 which were dated 6/7/10 and 10/12/11. On 12/1/11 at 3:00 p.m. review of resident #69's clinical record indicated he had diagnoses including but not limited to down syndrome,			

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	Alzheimer's disease and seizure disorder. Further review indicated the resident did have a responsible party listed on the "information face sheet" in his clinical record. 3.1-35(c)(2)(C) 3.1-35(d)(2)(B)			
F0282 SS=D	The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on record review and interview, the facility failed to administer beneprotein as ordered for 1 resident (Resident #40) and failed to follow up on a nephrology consult for 1 of 3 residents (resident #12) who met the criteria for urinary catheter in the stage 2 sample of 35. Findings include: 1. The record for Resident #40 was reviewed on 11/30/11 at 10:30 a.m. Diagnoses included, but were not limited to, end stage congestive heart failure, end stage renal disease, dementia, chronic obstructive pulmonary disease, and diabetes	F0282	F 282: Services by Qualified Persons per Care Plan:It is the practice of this facility to provide or arrange services that are provided by qualified person in accordance with each resident's written plan of care. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident #40 is currently receiving Beneprotein. Resident #12 refuses Nephrology Consultation. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? Residents who receive nutritional supplements have the potential to be affected by alleged deficient	12/29/2011

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	mellitus. A telephone order dated 2/22/11, indicated to administer beneprotein powder twice daily for 30 days. The March Routine Medication sheet indicated no beneprotein was administered from 3/1/11 through 3/20/11 as ordered. The interdisciplinary team note, dated 2/18/11, indicated Resident #40 was being discharged from hospice and that beneprotein was to be administered twice daily for 30 days. RN #11 was interviewed on 12/2/11 at 9:30 a.m. During the interview, RN #11 indicated the Medication Administration Record (MAR) needs to be initialed every time a medication or supplement is given. If something is not given, then you must circle the initials and write on the back of the MAR the reason it wasn't given. 2. Resident #12's record was reviewed on 11/28/11 at 4:35 p.m. The record indicated Resident #12's diagnoses included, but were not limited to history of bladder cancer, urinary retention, and multiple sclerosis. A Physician's Progress Note, dated		practice. Director of Nursing and/or designee will complete a chart audit for all residents receiving nutritional supplement to ensure all Physician orders are being followed. Residents who have been admitted or readmitted with catheters have the potential to be affected by alleged deficient practice. Director or Nursing and/or designee, to ensure that recommendations are followed, will review all residents' Physician progress notes. What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur? DNS and/or designee reviews all Physicians' orders in morning meeting 5 days a week to ensure orders are being followed. 2 nurses will review the monthly re-writes for accuracy. DNS and/or designee will review physician progress notes upon return from outside physician visits and all recommendations will be addressed. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? DNS and/or designee will use a Rewrite/Physician Visits CQI form to monitor weekly for 4 weeks, then monthly for 3 months, then quarterly for 6 months. Findings will be forwarded to the CQI committee monthly for review. An additional action plan will be	

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	11/4/10, indicated a recommendation for a nephrology consultation related to possible nephritic syndrome. During review of the clinical record, there was no documentation to indicate the recommendation had been addressed. An interview was conducted with the Director of Nursing (DON) on 11/30/11 at 2:40 p.m. During the interview, the DON indicated Resident #12 was followed by a local veterans hospital and that was probably why there was not much in the chart. She was unable to show documentation in the clinical record that the recommendation had been addressed or to verify that the appointment had taken place. 3.1-35(g)(2)		developed by the CQI committee for any findings below the threshold of 90%.	

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F0314 SS=D	Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. Based on observation, record review and interview the facility failed to ensure a wheelchair cushion was implemented for 1 resident (#69) in a stage 2 sample of 35 who was at risk for skin break down, and failed to follow their policy and procedure regarding implementation of a pressure reducing cushion. Finding Includes: On 11/30/11 at 12:00 p.m. observation of resident # 69 indicated he was seated in his wheelchair at the dining room table. The resident was not observed to have a pressure reduction cushion. On 11/30/11 at 2:00 p.m. Resident #69 was observed seated in the activity room in his wheelchair. The resident was not observed to have a pressure reduction cushion. On 12/1/11 at 8:15 a.m. Resident #69	F0314	F 314: Treatment/Services to Prevent/Heal Pressure Sores:It is the practice of this facility to ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Cushion put on Resident #69's chair on 12/01/11 and care plan and C.N.A. assignment sheet was updated. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? Residents with potential for skin breakdown have the potential to be affected by the alleged deficient practice. Review all residents with potential for skin breakdown and place cushions on wheelchair if needed and update care plans and C.N.A. assignment sheets to reflect change. What measures will be put into place or what systemic	12/29/2011

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	was seated in his wheelchair in the dining room. The resident was not observed to have a pressure reduction cushion. **On 12/1/11 at 9:00 a.m. Interview with the DON indicated she thought the resident had a cushion for his wheelchair.** **On 12/1/11 at 10:30 a.m. review of the Annual MDS (minimum data set assessment) dated 10/5/11 indicated resident #69 was totally dependent on staff for all of his activities of daily living. Review of the Care plan for resident #69, dated 11/19/10, indicated he was at risk for skin breakdown, but there was no intervention for a pressure reduction cushion.** **On 12/1/11 at 11:00 a.m. review of the clinical record indicated nursing notes for resident #69 as follows:** **10/25/11 at 6:45 a.m. "area noted to lower right buttocks. Area pink in color. No drainage noted. No odor noted. MD and nursing notified. New order for peleverus clear twice daily"**		changes will you make to ensure that the deficient practice does not recur? Resident skin assessments are performed weekly and residents identified with potential for skin breakdown will have a cushion placed on wheelchair and care plans and C.N.A. assignment sheets will be updated. Nurses to perform rounds to ensure that cushions are in place per care plan and C.N.A. assignment sheet. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? DNS and/or designee will use the Care Plan Updating CQI form weekly for 4 weeks, monthly for 3 months, then quarterly for 6 months to monitor compliance. Results will be forwarded to the CQI committee monthly for review. An additional action plan will be developed by the CQI committee for any findings below the threshold of 90%. DNS and/or designee will use the Skin Management CQI form weekly for 4 weeks, monthly for 3 months, then quarterly for 6 months. Results will be forwarded to the CQI committee monthly for review. An additional action plan will be developed by the CQI committee for any findings below the threshold of 90%.	

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	On 12/1/11 at 11:45 a.m. review of the facility policy for "Skin Management" dated 3/10 indicated the following: **Weekly skin assessments will be completed on all resident as follows:** Weekly skin assessments will be completed on all residents with or without alterations in skin integrity and documented on the weekly skin assessment form and/or nursing notes. **All alterations in skin integrity will be documented in one of two skin evaluation reports depending on what type of wound - either pressure wound (white) or other wound (lavender)** **Pressure reduction devices are to be put in place immediately.** **The care plan will be initiated/revised addressing any new areas.** **On 12/1/11 at 11:45 a.m. review of the plan of care for skin for resident #69, dated 11/19/10, indicated there was no addition of**			

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	a pressure relieving device being implemented for his wheelchair. 3.1-40(a)(1) 3.1-40(a)(2)			
F0325 SS=D	Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. Based on record review and interview, the facility failed to implement approaches to achieve acceptable parameters of nutritional status (protein levels) were achieved for 1 resident (#40)in the stage 2 sample of 35. Findings include: The record for Resident #40 was reviewed on 11/30/11 at 10:30 a.m. Diagnoses included, but were not limited to, end stage congestive heart failure, end stage renal disease,	F0325	F 325: Maintain Nutritional Status Unless Unavoidable:It is the practice of this facility to maintain acceptable parameters of nutritional status and to prescribe a therapeutic diet when there is a nutritional problem. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Registered Dietitian reviewed Resident #40 on 12/15/11. Lab levels were drawn on 12/08/11. Resident is currently on Beneprotein and care plan has been updated. Labs will be ordered per Physician orders. How will you identify other	12/29/2011

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	dementia, chronic obstructive pulmonary disease, and diabetes mellitus. Laboratory report, dated 09/23/10, listed a pre albumin level of 13.2 (18.0-35.7). and an albumin level of 2.3 (3.4-5.0) Laboratory report, dated 02/10/11, listed a pre albumin level 13.3 (18.0-35.7). The laboratory result for pre albumin, dated 2/10/11, indicated the level was low at 13.3 (18.0-35.7) for Resident #40. The Interdisciplinary Team (IDT) Progress Notes, dated 2/11/11, indicated Resident #40 had a pre albumin level of 13.2 on 9/22/10 and that they were waiting for the pre albumin level drawn on 2/10/11. Will continue with current plan. The Interdisciplinary Team (IDT) Progress Notes,dated 2/18/11, indicated Resident #40 was discharged from hospice and that beneprotein was to be started twice daily for 30 days. The Routine Medications sheet for February 2011, indicated Resident		residents having the potential to be affected by the same deficient practice and what corrective action will be taken? Resident who has pressure sores, significant weight changes, are on enteral feedings, or have abnormal labs affecting nutritional needs has the potential to be affected by the alleged deficient practice. Dietary Manager and/or Registered Dietitian will audit all dietary care plans on residents who have pressure sores, significant weight changes, have enteral feedings, or have abnormal labs affecting nutritional needs for any updates needed. What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur? Dietary Manager educated by Registered Dietitian on progress note documentation and dietary care plans on 12/15/11. DNS and/or designee will update Registered Dietitian alert sheets for residents of nutritional concerns, wounds, weight changes, and abnormal labs relating to nutritional status on weekly basis so Registered Dietitian can ensure appropriate follow up has occurred. Registered Dietitian to review a random sample of dietary care plans monthly and forward findings to the CQI committee monthly for review. How the corrective action(s) will be monitored to ensure the deficient	

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	#40 received beneprotein twice daily from 2/18/11 thru 2/28/11. The Routine Medications sheet for March 2011, indicated Resident #40 did not receive beneprotein during the month as ordered. The order had been yellowed out as if it was discontinued. The Routine Medications sheet for April 2011, indicated Resident #40 received beneprotein once daily from 4/511 thru the end of April. There was no documentation of beneprotein being administered from 4/1/11 thru 4/4/11. IDT 4/1/11, will request MD eval d/t decreased albumin/pre albumin et request supplements. MAR beneprotein powder started 4/5/11. The Routine Medications sheet for May 2011, indicated Resident #40 received one scoop of beneprotein daily from 5/1/11 thru 5/14/11 before being admitted to the hospital. Upon return, the sheet indicated the resident received beneprotein, one scoop daily from 5/27/11 thru 5/31/11. The Dietary Progress Note, dated 6/8/11, indicated to discontinue beneprotein and suggested double		practice will not recur, i.e., what quality assurance program will be put into place? Registered Dietitian to review a random sample of dietary care plans monthly and forward findings to CQI committee monthly for review. DNS and/or designee will utilize the Supplement CQI and the Care Plan CQI weekly for 4 weeks, monthly for 3 months, then quarterly for 6 months. Findings will be forwarded to the CQI committee monthly for review. An action plan will be developed by committee if threshold of 90% is not met.	

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	eggs at breakfast to increase protein. The note further indicated Resident #40 had been consuming 75% of breakfast. The Routine Medications sheet for June 2011, indicated Resident #40 received beneprotein one scoop daily for the month of June. Laboratory report, dated 06/16/11, listed a pre albumin level of 3.8 (18.0-35.7), and albumin level of 2.0 (3.4-5.0). The Dietary Progress Notes, dated 6/21/11, indicated Resident #40 was receiving beneprotein, one scoop in 8 ounces of water and that the resident had consumed breakfast 30%, lunch 35%, dinner 55%. The "Resident Progress Notes, "dated 8/24/11 by the Dietary Manager, indicated "...Resident remains on a regular diet...resident receives high potency vits (vitamins) and minerals...and beneprotein one scoop once a day...." The Routine Medications sheet, dated August 2011, indicated Resident #40 received beneprotein one scoop daily for the month of August.			

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	The Routine Medications sheet dated September 2011, indicated Resident #40 received beneprotein one scoop daily for the month of September. The current care plan, dated 9/22/11 for "Resident will be served prescribed diet,"was provided by the Director of Nursing on 12/1/11 at 10:45 a.m. The care indicated to monitor food consumption's, monitor labs, monitor weights, and serve regular diet. The Routine Medications sheet dated October 2011, indicated Resident #40 received beneprotein one scoop daily for the month of October. The "Resident Progress Notes," dated 11/16/11 by the Dietary Manager, indicated "...Resident remains on a regular diet...resident receives high potency vits (vitamins) and minerals...and beneprotein one scoop once a day...." The current meal tray card for Resident #40, was provided by the Dietary Manager on 12/01/11 at 11:06 a.m. The tray card listed Resident #40 as being on a regular diet with no special dietary supplemental interventions.			

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	The most recent "Routine Medications" list, dated 12/1/11, indicated Resident #40 was receiving beneprotein powder (protein supplement) once daily effective 4/5/11. On 12/2/11 at 11:00 a.m., the Certified Dietary Manager provided a copy of the current policy "Referrals to Dietitian," dated 5/06. The policy indicated "...facility staff will refer nutritional problems to the Registered and/or Licensed/Certified Dietitian using the appropriate form...as problems arise, staff will use the RD alert sheet provided to notify the Registered Dietitian of any concerns...routine referrals will be addressed on the dietitian's visit...the Dietary Services Manager and/or DNS/ADNS will provide the Dietitian with a list of the residents no less than monthly who: have pressure ulcers, significant weight changes, initiation/discontinuation of enteral feedings...." A telephone interview was conducted with the Registered Dietitian (RD) on 12/2/11 at 1:47 p.m. During the interview, the RD indicated she had not been notified of the low albumin levels. She indicated she is in the facility once a week or every other			

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	week and sees the residents on the alert sheet. Those residents with weight loss, wounds, etc. She further indicated she had not seen Resident #40 since she started her RD position back in July. The Certified Dietary Manager (CDM) was interviewed on 12/2/11 at 1:47 p.m., along with the RD. During the interview, the CDM indicated Resident #40 had refused supplements in the past and that she had tried other interventions such as peanut butter and toast. 3.1-46(a)(1)			

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F0329 SS=D	Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. Based on record review and interview, the facility failed to ensure lab tests were ordered to assess for the effectiveness of medication therapy for 1 of 10 residents (Resident #54) who met the criteria for unnecessary medication in the stage 2 sample of 35. Findings include: The record for Resident #54 was reviewed on 11/30/11 at 3:00 P.M. Diagnoses included, but were not limited to, hyperlipidemia (high levels of lipids, or fat, in the blood).	F0329	F 329: Drug Regimen is Free From Unnecessary Drugs:It is the practice of this facility to provide residents with a drug regimen that is free from unnecessary drugs. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident #54 admitted to facility on 07/05/11 with orders for prescribed medications and with necessary lab work. Labs were drawn on 12/01/11 and reviewed by the Physician with no new orders. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?	12/29/2011

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	A physician's order monthly recap for Resident #54 for December 2011, indicated the resident was prescribed Lipitor (medication used to lower lipid levels) 40 milligrams at bedtime and Tricor (medication used to lower lipid levels) 145 milligrams at bedtime. The record indicated the resident had been prescribed these medications since July 2011. A drug reference book, entitled "Nursing 2011 Drug Handbook", which was furnished by the DoN (Director of Nursing) on 12/2/11 at 8:00 A.M., indicated lab testing for baseline blood lipid levels should be obtained prior to starting therapy and then periodically thereafter for both Lipitor and Tricor. There was no indication in Resident #54's record of lab testing being obtained to assess for lipid levels since the Lipid and Tricor had been initiated. The consulting pharmacist signed the physician order monthly recaps for July 2011, August 2011, September 2011, October 2011, and November 2011 indicating Resident #54's medications had been reviewed. There were no recommendations in		Residents receiving Antilipemics have the potential to be affected by the alleged deficient practice. DNS and/or designee to review all residents receiving Antilipemics for need of additional lipid panel lab work. What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur? DNS and/or designee to review all new admission and re-admissions, within 72 hours, medications for necessary lab work if prescribed an Antilipemic. This is to be completed during morning meetings and information will be forwarded to the pharmacy consultant for review. DNS will review Antilipemic with pharmacy consultant on the next visit. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? DNS and/or designee to use the Lab Diagnostic CQI form weekly for 4 weeks, monthly for 3 months, then quarterly for 6 months and results forwarded to CQI committee monthly for review. DNS and/or designee will utilize the Supplement CQI and the Care Plan CQI weekly for 4 weeks, monthly for 3 months, and then quarterly for 6 months. Findings will be forwarded to the CQI committee monthly for review. The CQI committee will develop an action plan if	

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	the record to indicate the pharmacist had addressed monitoring lipid levels. The facility DoN was interviewed on 12/1/11 at 3:40 P.M. During the interview, the DoN indicated no lab tests for lipid levels had been obtained for Resident #54. The DoN indicated the consulting pharmacist had reviewed Resident #54's medications, but had made no recommendations regarding monitoring lipid levels. The DoN further indicated the facility's current pharmacy did not make as many recommendations for lab tests in the medication reviews as the previous pharmacy had done. 3.1-48(a)(3)		threshold of 90% is not met.	
F0333 SS=D	The facility must ensure that residents are free of any significant medication errors. Based on observation, record review and interview the facility failed to ensure insulin was given at the appropriate time for 2 of 16 residents (#25 & #3) observed during medication administration in the stage 2 sample of 35.	F0333	F 333: Residents Free From Significant Med ErrorsIt is the practice of this facility to ensure that residents are free of any significant medication errors. What corrective action(s) will be accomplished for those residents found to have been affected by	12/29/2011

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	Finding Includes: 1. Observation of medication pass on 12/1/11 at 3:20 p.m. indicated resident #25 had a blood sugar of 179. Review of the residents medication administration orders indicated the resident was to receive 2 units of Novolin-R insulin. Nurse #19 drew up the insulin and administered it to the resident. Observation of medication pass on 12/1/11 at 3:25 p.m. indicated resident #3 had a blood sugar of 415. Nurse #19 phoned the physician related to the high blood sugar and was told there was no new order. Observation of nurse #19 indicated she drew up 12 Units of Humalog 100 Insulin as was ordered and administered the insulin to the resident. On 12/1/11 at 3:30 p.m. interview with nurse #8 indicated the residents do not receive their evening meal until 5:45 p.m. On 12/2/11 at 9:15 a.m. the Director of Nursing supplied the insulin information sheets. Review of the medication information sheets indicated the insulin should be given within 15 minutes of starting a meal to 20 minutes after starting a meal depending on regimen.		the deficient practice? There was no negative outcome from this alleged deficient practice on Resident #25 and Resident #3. Individual education for Nurse #19 will occur by 12/29/11. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents receiving short acting insulin have the potential to be affected by alleged deficient practice. An audit of all resident medication administration records will be done to identify residents who receive short acting insulin. Physician will be notified of the administration guidelines and orders will be obtained in order to be in compliance with the short acting insulin guidelines. What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur? Residents receiving short acting insulin have been reviewed and changes have been made to sliding scale to ensure timeliness of administration of insulin. DNS and/or designee will review physician orders during morning meeting to ensure physician orders follow guidelines. A skills check off list will be completed by Unit Manager and/or designee on all nurses to ensure they are following the insulin protocols. How the corrective action(s) will be monitored to ensure the	

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	On 12/2/11 at 10:30 a.m. review of "Mosby's 2012 Nursing Drug Reference" indicated Novolin-R insulin is a short acting insulin with an onset of action at 30 minutes and Humalog insulin is a rapid acting insulin with an onset of 15 to 30 minutes. 3.1-25(b)(9) 3.1-48(c)(2)		deficient practice will not recur, i.e., what quality assurance program will be put into place? DNS and/or designee to use the MAR/TAR CQI form weekly for 4 weeks, monthly for 3 months, then quarterly for 6 months thereafter. Results will be forwarded to the CQI committee monthly for review. If threshold of 90% is not met, then CQI committee will develop an additional action plan. DNS and/or designee, using the IDT admission/readmission review tool, will review all new admissions and re admissions to ensure residents who receive short acting insulin will have orders that reflect protocol. A new blood glucose-monitoring tool has been implemented showing the actual time the short acting Insulin is administrated per Physician's orders and manufacturer's guidelines. This tool will be used daily for the next 1 month, then monthly for 6 months. If the threshold of 90% is not met; the CQI committee will implement an action plan. Non-compliance may result in disciplinary action up to and including termination.	

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F0412 SS=D	The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist. Based on observation, record review and interview the facility failed to assess and provide dental services for 1 of 3 residents (#55) who met the criteria for dental status and services. Finding includes: Observation of resident #55 on 11/28/11 at 2:00 p.m. indicated the resident had broken and decayed teeth on the upper and lower portion of her mouth. On 11/30/11 at 10:15 a.m. review of the resident's admission nursing assessment dated 4/5/10, indicated the resident had reddened gums. Review of the quarterly MDS (minimum data set) dated 9/22/11 there was no assessment marked in the dental section. On 12/2/11 at 10:30 a.m. Interview with the director of nursing indicated	F0412	F 412: Routine/Emergency Dental Services in NFS:It is the practice of this facility to provide or obtain from an outside resource, routine and emergency dental services to meet the needs of each resident. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident #55 was assessed for any pain with gums and/or mouth and no pain was noted. Resident #55 does not want a dental appointment immediately, at resident's request of wanting to wait 3 to 4 months, an appointment was made for March 5, 2012. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents have the potential to be affected by the alleged deficient practice? Social Services Director and/or designee will review all residents' most current dental assessment for any dental needs and follow up accordingly. What measures will be put into	12/29/2011

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	she did not have any information regarding resident #55 being seen by a dentist. The only information was the initial assessment of the resident's teeth which indicated reddened gums. On 12/2/11 at 10:33 a.m. interview with the Social Service Director indicated the resident had not been seen by a dentist and she did not have any documentation of the resident being asked on admission if she needed/wanted to be seen by the dentist. 3.1-24(a)(1)		place or what systemic changes will you make to ensure that the deficient practice does not recur? Interdisciplinary Team will review oral assessments during resident's care plan review. Nurses are responsible to complete oral assessments on all residents and Social Services will follow up on any needs. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? Social Services Director and/or designee to perform the Dental Service CQI for dental services weekly for 4 weeks, monthly for 3 months, then quarterly for 6 months and forward findings for CQI committee monthly for review. The CQI committee will develop an additional action plan for any findings not meeting the threshold of 90%.	
F0428 SS=D	The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. Based on record review and interview,	F0428	F 428: Drug Regimen Review, Report Irregular and Act On: It is the practice of this facility to have	12/29/2011

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	the facility's consulting pharmacy had failed to recommend lab tests were ordered to assess for the effectiveness of medication therapy for 1 of 10 residents (Resident #54) reviewed for unnecessary medications in a stage 2 sample of 35. Findings include: The record for Resident #54 was reviewed on 11/30/11 at 3:00 P.M. Diagnoses included, but were not limited to, hyperlipidemia (high levels of lipids, or fat, in the blood). A physician's order monthly recap for Resident #54 for December 2011, indicated the resident was prescribed Lipitor (medication used to lower lipid levels) 40 milligrams at bedtime and Tricor (medication used to lower lipid levels) 145 milligrams at bedtime. The record indicated the resident had been prescribed these medications since July 2011. A drug reference book, entitled "Nursing 2011 Drug Handbook", which was furnished by the DoN (Director of Nursing) on 12/2/11 at 8:00 A.M., indicated lab testing for baseline blood lipid levels should be obtained prior to starting therapy and		a Licensed Pharmacist review each resident's drug regimen. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident #54 admitted to facility on07/05/11 with orders for prescribed medications and with necessary lab work. Labs were drawn on 12/01/11 and reviewed by the Physician with no new orders. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? Residents receiving Antilipemics have the potential to be affected by the alleged deficient practice. DNS and/or designee to review all residents receiving Antilipemics for need of additional lipid panel lab work. What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur? DNS and/or designee to review all new admission and re-admissions, within 72 hours, medications for necessary lab work if prescribed an Antilipemic. DNS will review Antilipemic with pharmacy consultant on next visit. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? DNS and/or designee to use the Lab Diagnotic CQI form weekly for 4 weeks, monthly for 3	

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	then periodically thereafter for both Lipitor and Tricor. There was no indication in Resident #54's record of lab testing being obtained to assess for lipid levels since the Lipid and Tricor had been initiated. The consulting pharmacist signed the physician order monthly recaps for July 2011, August 2011, September 2011, October 2011, and November 2011 indicating Resident #54's medications had been reviewed. There were no recommendations in the record to indicate the pharmacist had addressed monitoring lipid levels. The facility DoN was interviewed on 12/1/11 at 3:40 P.M. During the interview, the DoN indicated no lab tests for lipid levels had been obtained for Resident #54. The DoN indicated the consulting pharmacist had reviewed Resident #54's medications, but had made no recommendations regarding monitoring lipid levels. The DoN further indicated the facility's current pharmacy did not make as many recommendations for lab tests in the medication reviews as the previous pharmacy had done.		months, then quarterly for 6 months and forward results to the CQI committee monthly for review. The CQI committee will develop an additional action plan for any findings not meeting the threshold of 90%.	

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F0514 SS=D	3.1-25(i) The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. Based on record review and interview, the facility failed to ensure documentation by the Registered Dietitian (RD)/Certified Dietary Manager (CDM) was accurate for 1 resident (#40) in a stage 2 sample of 35. Findings include: Laboratory report, dated 2/10/11, indicated Resident #40 had a low pre albumin. The Nutrition Risk Assessment, dated 4/5/11, indicated lab values for albumin and other nutrition related lab values were within normal limits. The Physician's Progress Notes, dated 4/5/11, indicated Resident #40	F0514	F 514 Records Complete/Accurate/Accessible:It is the practice of this facility to maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident #40 dietary care plan updated on 12/15/11. Resident #40 documentation completed on 12/15/11. Registered Dietitian reviewed Resident #40 on 12/15/11. Lab levels were drawn on 12/08/11. Resident is currently on Beneprotein and care plan has been updated. Labs will be ordered per Physician orders. How will you identify other residents having the potential to be affected by the same deficient	12/29/2011

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	had a diagnosis of malnutrition with last pre albumin recorded as 13.3 (18-35.7). The Nutrition Risk Assessment, dated 5/27/11, indicated lab values for albumin and other nutrition related lab values were within normal limits. Laboratory report, dated 6/16/11, indicated Resident #40 had a low albumin, total protein and albumin levels. The Nutrition Risk Assessment, dated 6/21/11, indicated lab values for albumin and other nutrition related lab values were within normal limits. An interview was conducted with the Director of Nursing and Health Facility Administrator on 12/2/11 at 9:00 a.m. During the interview, the Director of Nursing indicated the notes prior to July were the previous dietitian. 3.1-50(a)(1) 3.1-50(a)(2)		practice and what corrective action will be taken? Resident who has pressure sores, significant weight changes, are on enteral feedings, and/or have abnormal labs affecting nutritional status has the potential to be affected by the alleged deficient practice. Dietary Manager and/or Registered Dietitian will audit all dietary care plans on residents who have pressure sores, significant weight changes, have enteral feedings, or abnormal labs affecting nutritional status for any updated needed. What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur? Dietary Manager educated on progress note documentation and dietary care plans on 12/15/11. DNS and/or designee will update Registered Dietitian alert sheets for residents of nutritional concern, wounds, weight changes, and abnormal labs relating to nutritional status on weekly basis. Registered Dietitian to review a random sample of dietary care plans monthly and forward findings to the CQI committee monthly for review. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? DNS and/or designee will utilize the Supplement CQI and the Care Plan CQI weekly for	

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			4 weeks, monthly for 3 months, then quarterly for 6 months thereafter. Findings will be forwarded to the CQI committee monthly for review. The CQI committee for any findings not meeting the threshold of 90% will develop an action plan. Registered Dietitian to review a random sample of dietary are plans monthly and forward findings to the CQI committee monthly for review. Dietary Manger and/or designee will use the Dietary Recommendation CQI tool weekly for 4 weeks, monthly for 3 months, then quarterly for 6 months. Findings will be forwarded to the CQI committee monthly for review. The CQI committee for any findings not meeting the threshold of 90% will develop an action plan.	